MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

March 21, 2002

Beneficiaries' access to Medicare hospice care

ISSUE: Do terminally ill Medicare beneficiaries have difficulty accessing hospice care? Do rural beneficiaries have poorer access to hospice care than their urban counterparts? To address these questions, the Congress required MedPAC to study beneficiaries' access to and use of hospice care and to report in June 2002.

KEY POINTS: Beneficiaries have greater access to hospice care today than in the early 1990s, as evidenced by two indicators: beneficiaries' use of care and supply of providers. The number of beneficiaries and percentage of decedents using hospice more than doubled from 1992 to 1998—20 percent of decedents and half of beneficiaries who died of cancer used hospice in 1998. Hospice users of every type increased during this period with the greatest growth among beneficiaries with non-cancer diagnoses, and those living in nursing homes or rural areas. The number of Medicare hospices increased 82 percent from 1992 to 1998; fewer than 2 percent of beneficiaries now live in areas with no hospice available.

Empirical evidence that minorities and beneficiaries without supplemental insurance have very low use of hospice may suggest access problems for these individuals. However, the literature and our key informants suggest low use by minority beneficiaries results from cultural attitudes. That beneficiaries without Medigap have low use rates is more difficult to interpret, although not having supplemental insurance coincides with lower income and being nonwhite.

Some believe that short hospice stays indicate access problems. From 1992 to 1998, the fraction of hospice patients dying within one week of admission increased from 21 percent to 28 percent. We conclude that Medicare policies are not a major contributor to shorter hospice stays. Instead, the main causes of these late referrals appear to be 1) the difficulty of making prognoses of death within six months, 2) beneficiaries' unwillingness to give up curative care, and 3) greater availability of non-debilitating therapies. We also conclude that Medicare policies are not a barrier to beneficiaries accessing hospice care.

To protect beneficiaries' access to hospice care, Medicare payment rates must be adequate. Currently, rates are based on old information from a Medicare demonstration project in the early 1980s. Although the initial rates have been updated for inflation over time, they probably are not consistent with the costs that efficient hospices incur in furnishing care. Rapid growth in providers can mean that rates are too generous; the hospice industry maintains that rates are too low. Therefore, rates need to be evaluated once hospice cost reports are available later this year. In addition, hospice rates are not case-mix adjusted. A short and simple assessment instrument might improve the accuracy of the rates and physicians' ability to make prognoses.

ACTION: Commissioners will discuss findings and draft recommendations. The results of their discussion will be incorporated into the draft report that they will review at the April meeting.

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